CERTIFICATE OF NEED
FOR EMERGENCY INVOLUNTARY ADMISSION
UNDER TITLE 33, CHAPTER 6, PART 4, TENNESSEE CODE ANNOTATED

I, _____, of the County of _____,
PRINT NAME OF EXAMINING PROFESSIONAL

State of Tennessee, **certify** that I personally examined _____
PRINT NAME OF PERSON EXAMINED

on _____, 2_____ at _____ AM / PM.
DATE YEAR TIME

→ **COMPLETE SECTION A, C, D AND E FOR THE FIRST CERTIFICATE OF NEED**
→ **COMPLETE SECTION B, C, AND E FOR THE SECOND CERTIFICATE OF NEED**

A

Check all that apply:

☐ I **am not** a Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) Commissioner- designated mandatory pre-screening agent.

And, I **am** a (*check one*):

☐ licensed physician ☐ licensed psychologist designated as a health service provider

Please Complete the Following:

☐ I have completed this certificate because a mandatory pre-screening agent was **not** available within 2 hours **AND**

☐ I have consulted with the mental health crisis team in my area and have determined that all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person as indicated in **Section C, # 4** below.
I spoke with _____, _____.
STAFF NAME TITLE / AGENCY

OR

☐ I am a Qualified Mental Health Professional (QMHP) who has been designated by the TDMHSAS Commissioner as a mandatory pre-screening agent. *****

QMHP: licensed physician, licensed psychologist designated as a health service provider, licensed psychological examiner, Licensed senior psychological examiner, certified social worker with two years of mental health experience, licensed social worker, licensed or certified marital and family therapist, licensed professional counselor, licensed nurse with a masters degree in nursing who functions as a psychiatric nurse, or licensed physician's asst. with a master's degree & expertise in psychiatry as determined by training, education or experience.

***** A TDMHSAS Commissioner-designated mandatory pre-screening agent must have mental health experience with children in order to complete a Certificate of Need on a child.

B

☐ I **am** a licensed physician. [ONLY for completing second certificate at the time of admission.]

C

In my professional opinion, based on the examination and the information provided, I certify that this person is subject to involuntary care and treatment under Title 33, Chapter 6, Part 4, Tennessee Code Annotated because, as shown by the following facts and reasoning, the person:

1. has a mental illness or serious emotional disturbance as defined in T.C.A. § 33-1-101(16) and (20), (**list known mental illness or serious emotional disturbance history and current signs/symptoms**):
   Mental illness is a psychiatric disorder, alcohol dependence or drug dependence; does not include mental retardation / developmental disabilities. ***Serious emotional disturbance*** is a condition in a **child** who at any time during the past year has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet psychiatric diagnostic criteria, that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities and includes any mental disorder, regardless of whether it is of biological etiology.

   _____
   _____
   _____
   _____
   _____

2. **AND**, poses an immediate substantial likelihood of serious harm under T.C.A. § 33-6-501 because of the mental illness or serious emotional disturbance (**detail specific behavior substantiating this requirement**):
   A person "poses an immediate substantial likelihood of serious harm" IF AND ONLY IF the person:
   - has threatened or attempted suicide or to inflict serious bodily harm on such person, or
   - has threatened or attempted homicide or other violent behavior, or
   - has placed others in reasonable fear of violent behavior and serious physical harm to them, or

PRINT NAME OF PERSON EXAMINED | DATE | TIME

C

CONTINUED

- is unable to avoid severe impairment or injury from specific risks, **AND**
- there is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment.

_____
_____
_____
_____
_____

3. **AND**, needs care, training, or treatment because of the mental illness or serious emotional disturbance (**describe what makes care, training or treatment necessary**):

_____
_____
_____
_____
_____

4. **AND**, all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person (**list alternatives considered and rationale for rejection of all alternatives**):

_____
_____
_____
_____

D

Having certified that this person is subject to involuntary care and treatment under Title 33, Chapter 6, Part 4, Tennessee Code Annotated, I further certify that this patient:

☐ May be transported to a TDMHSAS designated telehealth location for a second certificate of need (CON) examination

OR

☐ Requires direct transportation to an admitting psychiatric facility for a second certificate of need (CON) examination

AND

☐ May be transported to an admitting psychiatric facility or TDMHSAS designated telehealth location for 2nd CON examination pursuant to T.C.A. § 33-6-901 by an available friend, neighbor, mental health professional familiar with the individual, relative or a member of the clergy

OR

☐ May be transported to an admitting facility or TDMHSAS designated telehealth location for 2nd CON examination by ambulance or secondary transportation agent designated by the sheriff

OR

☐ Must be transported to an admitting facility or TDMHSAS designated telehealth location for 2nd CON evaluation by sheriff/law enforcement

E

WITH MY SIGNATURE:

- I conclude that this person is subject to admission to a hospital or treatment resource under Title 33, Chapter 6, Part 4, Tennessee Code Annotated.
- The information is accurate and based upon my (check one):
  ☐ **FACE-TO-FACE** examination of the individual ☐ **TELEHEALTH** examination of the individual
- I understand that completion of this certificate of need initiates a process, which may result in deprivation of an individual's liberty for the purposes of care, training or treatment.
- I understand that to willfully provide inaccurate information on this certificate of need constitutes a crime.

_____ _____
PRINT NAME OF EXAMINING PROFESSIONAL | SIGNATURE OF EXAMINING PROFESSIONAL

_____ _____ _(_____)_____
DATE | TIME | PHONE NUMBER